Phone: 405-594-7855 Fax: 405-594-7824

Welcome to the Stetson Spine Clinic! Thank you for choosing our practice for your neurosurgical spine care. We understand that dealing with spine and nerve conditions can be physically challenging and emotionally overwhelming, and we are honored to be part of your healthcare journey.

Our mission is to provide exceptional patient-centered care by using the latest evidence-based treatments and surgical techniques. We believe that every patient deserves to be heard, understood, and treated with respect. From your first appointment through recovery and follow-up care, we are committed to helping you feel informed, comfortable, and supported every step of the way.

Your appointment is scheduled:

Date: _____

Time: _____ (please arrive <u>at least</u> 15 minutes early)

Location: _____

Provider: ☐ Dr. Nate Stetson, DO

☐ Jenna Taylor, DNP, APRN

Attached is your New Patient Paperwork. <u>Please complete ALL pages</u>. We must have this paperwork in place before providing treatment. *If you do not complete the paperwork before your appointment, please arrive <u>at least 30 minutes early</u> to do so before you receive treatment.*

Please bring the following with you to your appointment:

- Driver's license
- Medical insurance cards
- Discs with any spine imaging completed in the last *12 months*
- Current medication list

Patient Information:

Full Name:		Preferred Name:	
Date of Birth:	Age:	Gender:	SSN:
Marital Status:	Address:		
City:		State:	Zip:
Cell Phone:		Home Phone:	
Work Phone:	Email:		
Preferred Language: ☐ English ☐ Spanish ☐ Other:			
Emergency Contact Name:		HIPAA Approved: ☐ Yes ☐ No	
Phone Number:		Relationship to Patient:	
Primary Care Provider's Name:		Phone Number:	
Person Who Referred You to Our Office:			
Employer Name:		Occupation:	
If you have Sooner Care and have primary insurance (other than Sooner Care) You MUST provide us with the primary insurance information. Your Sooner Care will not pay until your primary insurance has processed the claim. If Sooner Care shows you have other primary insurance inaccurately, we will require that you provide us a valid termination date of that insurance and that you contact Sooner Care with that termination date.			
Name of Primary Insurance Company:			
Policy #:		Group #:	
Policy Holder Name:		Relationship to Patient:	
Policy Holder DOB:	Policy Holder Employer:		
Name of Secondary Insurance Company:			
Policy #:		Group #:	
Policy Holder Name:		Relationship to Patient:	
Policy Holder DOB:	Policy Holder Employer:		
Is this an injury related to a Motor Vehicle Accident? ☐ Yes ☐ No		Date of Accident:	
Do you have a Lawyer? ☐ Yes ☐ No	Name of Law Firm:		
Is this a Workers Compensation Injury? ☐ Yes ☐ No		Employer:	
Date of Injury:		Date Pain Began:	
Are you Currently Working? ☐ Yes ☐ No	If no, last day worked:		
Current Restrictions:			
Adjuster's Name:		Phone Number:	
Claim Number:			

Please check only the symptoms you are experiencing ***today***:

Constitutional:
- ☐ Change in appetite
- ☐ Chage in energy
- ☐ Fatigue
- ☐ Fever
- ☐ Insomnia
- ☐ Recent weight change

Eyes:
- ☐ Change in vision
- ☐ Double vision
- ☐ Eye/vision problems
- ☐ Spots before eyes
- ☐ Wears glasses/contacts

Ear / Nose / Mouth / Throat:
- ☐ Difficulty swallowing
- ☐ Congesting
- ☐ Dental problems
- ☐ Earaches
- ☐ Hearing loss
- ☐ Ringing in the ears
- ☐ Hoarse voice
- ☐ Mouth sores
- ☐ Nose bleeds
- ☐ Sinus problems

Cardiovascular:
- ☐ Cardiac device implantation
- ☐ Chest pain
- ☐ Cold extremities
- ☐ Irregular/ abnormal heartbeat
- ☐ Swelling of the feet/ankles
- ☐ Varicose veins

Gastrointestinal:
- ☐ Abdominal pain
- ☐ Bloody stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Loss of appetite
- ☐ Nausea/vomiting

Genitourinary:
- ☐ Abnormal periods
- ☐ Bladder control problems
- ☐ Blood in urine
- ☐ Change in force of stream
- ☐ Frequent urination
- ☐ Incomplete emptying
- ☐ Kidney stones
- ☐ Painful/burning urination
- ☐ Painful intercourse
- ☐ Pelvic pain
- ☐ Sexual transmitted infection (STI)
- ☐ Stress incontinence
- ☐ Testicular/prostate pain
- ☐ Unable to keep an erection

Musculoskeletal:
- ☐ Back pain
- ☐ Joint pain/swelling
- ☐ Muscle joint weakness
- ☐ Weak bones

Derm/Breast/ Integumentary:
- ☐ Breast feeding
- ☐ Breast lump
- ☐ Breast pain
- ☐ Hair loss
- ☐ Nipple discharge/bleeding
- ☐ Jaundice/yellow skin
- ☐ Rash/dry skin/itching
- ☐ Sensitivity to light
- ☐ Ulcerations

Neurological:
- ☐ Change in speech
- ☐ Confusion
- ☐ Headaches
- ☐ Migraines
- ☐ Light headed/dizzy
- ☐ Numbness
- ☐ Paralysis
- ☐ Problems with balance
- ☐ Seizures

Psychiatric:
- ☐ Anxiety
- ☐ Frequent crying
- ☐ Memory loss
- ☐ Nervousness
- ☐ Depression

Respiratory
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing
- ☐ CPAP

Hematological / Lymphatic:
- ☐ Anemia
- ☐ Bleeding / bruising
- ☐ Enlarged lymph nodes
- ☐ History of blood transfusions
- ☐ Slow to heal after cuts
- ☐ Swollen/painful glands

Allergy/Immunologic:
- ☐ Allergies
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Immunocompro-mised

Health History:

Please list all ***medical problems*** that you have been diagnosed with (diabetes, high blood pressure, heart failure, COPD, asthma, autoimmune diseases, etc.):

1.	**10.**
2.	**11.**
3.	**12.**
4.	**13.**
5.	**14.**
6.	**15.**
7.	**16.**
8.	**17.**
9.	**18.**

Please list all ***previous spine surgeries*** that you have had

Surgery	Date	Surgeon
1.		
2.		
3.		
4.		
5.		

Allergies:

Medication/Other	Reaction:
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Medications:

Pharmacy Name: _____ Phone Number: _____
Address: _____

Current Medications:

Medication Name	Medication Dosage/Frequency

Social History:

- Work status:
  ☐ Working ☐ Not working ☐ Retired ☐ Disabled ☐ Applying for Disability
  Occupation _____
- Nicotine use:
  ☐ Never ☐ Former ☐ Current
  Type: ☐ Cigarettes/Cigars ☐ Vape ☐ Smokeless ☐ Patches/Gum/Lozenges
  Amount and Duration: _____
- Alcohol use:
  ☐ None ☐ Occasional ☐ Regular
  Amount and Frequency: _____
- Recreational drug use
  ☐ Yes ☐ No ☐ Past usage
  Type and Frequency: _____

Spine History:

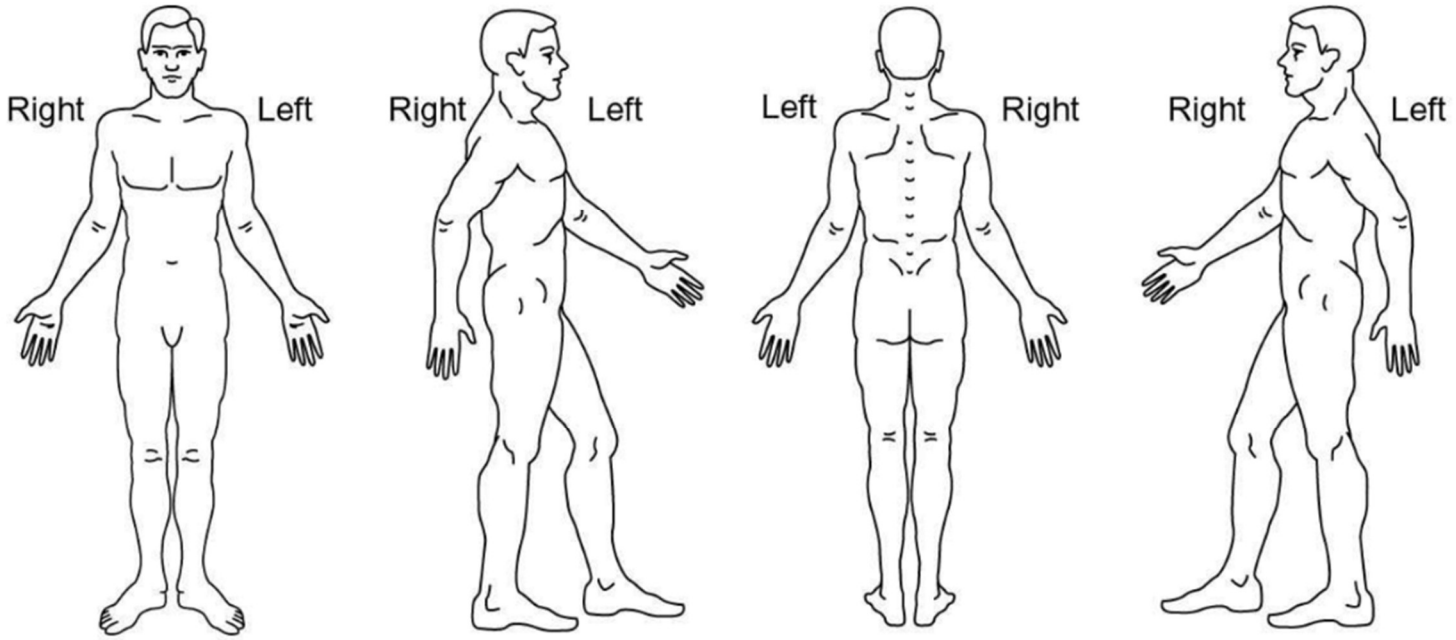
- Primary reason for today's visit:

- When did the pain **first start**? (approximate month and year):

- Is the pain getting progressively worse? Yes No Unchanged
    - When did the pain start to worsen? _____

- How would you rate your average pain on a scale of 1 to 10 (with 10 being the worst)? _____/10
- How would you rate your worst pain on a scale of 1 to 10 (with 10 being the worst)? _____/10

On the diagram below, please **place X's** the area of your spine where the pain starts and **place arrows** to show where it radiates:



- Describe your typical pain
  ☐ Aching ☐ Burning ☐ Cramping ☐ Dull ☐ Electrical ☐ Pressure ☐ Sharp ☐ Shooting
  ☐ Spasming ☐ Stabbing ☐ Squeezing ☐ Stabbing ☐ Tender ☐ Throbbing ☐ Tightness
  ☐ Other: _____

- What activities make the pain WORSE?
  ☐ Bending ☐ Changing positions ☐ Computer/Deskwork ☐ Driving ☐ Exercise
  ☐ House/Yard work ☐ Lifting ☐ Looking up ☐ Lying down ☐ Reaching ☐ Sitting
  ☐ Squatting ☐ Standing ☐ Stairs ☐ Stretching ☐ Twisting ☐ Walking
  ☐ Other _____
    - How long can you stand before you need to sit down? _____
    - How far can you walk before you need to sit down? _____
    - Do you need to use something to help you walk?
      - ☐ No assistance needed ☐ Cane ☐ Walker ☐ Other: _____
      - How long have you been using this assistance? _____

- What helps to make the pain BETTER?

- Do you have *numbness* or areas without feeling (NOT tingling)? Yes No
  - If yes, where? _____
  - Is it constant, or does it come and go? _____
  - When did it become constant? _____
  - Is your groin numb? Yes No

- Do you have *tingling*? Yes No
  - If yes, where? _____

- Do you have *weakness*? Yes No
  - If yes, where? _____

- Do you have difficulty with dexterity (difficulty grasping, picking up or holding small things or frequently dropping things)?
  Yes No

- Have you lost control of your bladder or bowels without knowing that you needed to go?
  Yes No
  - If so, how long ago and how many times? _____

Prior Non-surgical Treatment:

List medications you are ***currently*** taking for pain, as well as amount and how often you take them:

- Over the counter medications (Tylenol, Ibuprofen, etc.)
- Anti-inflammatory meds (meloxicam, naproxen, etc.)
- Narcotics (oxycodone, hydrocodone, tramadol, etc.)
- Muscle relaxers (cyclobenzaprine, tizanidine, methocarbamol, baclofen, etc.)
- Antidepressants (duloxetine, etc.)
- Nerve medications (gabapentin, pregabalin, carbamazepine, etc.)

1.
2.
3.
4.
5.
6.

- Have you had physical therapy *for the spine in the past year*? Yes No

  If yes, how many sessions: _____ What date range: _____

  Did it completely relieve your pain? Yes No

- Have you had steroid injection *in the spine in the past year*? Yes No

  Did you have improvement? Yes No How long did the injection help? _____

  How many did you have total? _____ When was the last injection? _____

  Doctor's name: _____

- What conservative measures or complimentary therapies have you tried for your pain in the last *12 months*?
  - ☐ Traction devices or inversion tables
  - ☐ Massage
  - ☐ Acupuncture
  - ☐ Chiropractic
  - ☐ Osteopathic manipulation
  - ☐ Exercise/stretching
  - ☐ Anti-inflammatories

Other History:

Have you had any major trauma in the past year (motor vehicle collision, major fall, etc.)? If so, what and when? _____ _____	**Yes**	**No**
Any complete loss of bowel or bladder control without knowing (not urinary urgency or frequency)?	**Yes**	**No**
Any complete loss of sensation (not tingling) in the groin, or area between your genitals and anus?	**Yes**	**No**
Any current weakness in one extremity or area?	**Yes**	**No**
Do you have history of osteoporosis (weak/brittle bones)?	**Yes**	**No**
Have you ever had any heart attacks/strokes/leg clots/pulmonary emboli?	**Yes**	**No**
Do you have a personal history of cancer or recent unexplained weight loss?	**Yes**	**No**
Have you used narcotic medications for longer than 3 months?	**Yes**	**No**
Do you have any history of substance abuse or IV drug abuse?	**Yes**	**No**
Have you used oral steroids for more than 3 months?	**Yes**	**No**
Do you have any disease or take any medication which increases your risk of infection (diabetes, HIV/AIDS, cancer, chronic lung disease, kidney disease, autoimmune disorders, etc.)?	**Yes**	**No**
Do you have fibromyalgia or a complex pain syndrome?	**Yes**	**No**
Have you had previous spine surgery?	**Yes**	**No**
Do you have a history of vascular problems or vascular claudication?	**Yes**	**No**
Do you have any pending litigation, car accident claims, or worker's compensation claims?	**Yes**	**No**
Do you rate your pain as severe?	**Yes**	**No**
Do you have multiple areas of your body that hurt?	**Yes**	**No**
Do you use products that contain nicotine (smoking/vaping/chewing)?	**Yes**	**No**
Do you have any psychiatric diagnosis (anxiety, depression, bipolar, PTSD, etc.)?	**Yes**	**No**
Do you believe you may never get better?	**Yes**	**No**
Is your job physically demanding?	**Yes**	**No**
Do you believe that you will not be working in 6 months?	**Yes**	**No**
Are you currently applying or planning on applying for disability?	**Yes**	**No**

Please list all other providers you are established with:

Primary Care
Provider's name: _____ Phone number: _____
Clinic name: _____

Physical Therapy
Clinic name: _____ Phone number: _____

Pain Management
Provider's name: _____ Phone number: _____
Clinic name: _____

Cardiology
Provider's name: _____ Phone number: _____
Clinic name: _____
Condition(s) being managed: _____

Pulmonology
Provider's name: _____ Phone number: _____
Clinic name: _____
Condition(s) being managed: _____

Nephrology
Provider's name: _____ Phone number: _____
Clinic name: _____
Condition(s) being managed: _____

Endocrinology
Provider's name: _____ Phone number: _____
Clinic name: _____
Condition(s) being managed: _____

Hematology/Oncology
Provider's name: _____ Phone number: _____
Clinic name: _____
Condition(s) being managed: _____

Rheumatology
Provider's name: _____ Phone number: _____
Clinic name: _____
Condition(s) being managed: _____

Patient Signature: _____ **Date: _____**